

# Introducing Qualitative Research into a Psychology Program: Co-Learning, Hospitality and Rigour

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## Abstract

I am an academic in the Clinical Psychology Unit in the School of Psychology, University of Sydney and convenor of Qualitative Research in Psychology, a group with ninety members from within the Unit, the School and other disciplines and Universities. The aim of this paper is to describe the evolution of this group and the promotion of qualitative methods within a discipline traditionally aligned with quantitative research. I will describe three factors that I see as contributing towards these developments; a focus on co-learning with students and academics using innovative teaching methods, an ethic of hospitality towards quantitative research colleagues and an insistence on high standards to establish the trustworthiness of research findings. Examples of three studies conducted by students will be provided.

## Introduction

Quantitative and qualitative research methods offer distinctly different yet potentially complementary perspectives (Mahoney & Goertz, 2006). Quantitative research is traditionally hypothesis-driven, aiming to objectively test ideas based on numerical data and statistical analysis. The researcher uses a variety of tools for data collection, including questionnaires, surveys or laboratory equipment and findings are considered generalizable to a population larger than the sample studied. Qualitative research is exploratory, rather than confirmatory, aiming to embrace the complexity of subjective phenomenon whilst synthesising findings through the analysis of meaning. The primary tool for data collection is the researcher themselves, via interviews, focus groups and observation and the generalizability of findings is not assumed. It is important to recognise, however, that qualitative research is an umbrella term for a great diversity of methodologies. Grounded theory, for example, develops models to reflect phenomenon (Charmaz, 2000) while narrative analysis maintains the integrity of the participant's accounts (Clandinin & Connelly, 2000), ethnography aims to understand cultures from the perspective of an embedded observer (Geertz, 1973) while community-based action research promotes collaborative intervention (Wallastein & Duran, 2003). Qualitative research has its origins in anthropology and sociology in the early 20<sup>th</sup> century (Flick, 2005), originally in the study of colonial cultures. Since then, however, it has developed exponentially, becoming established not only in the social sciences but also in education (Lichtman, 2009), nursing (Gardner, 1996) and increasingly in medicine (Shuval, Harker, Roudsari, Groce, Mills, Siddiqi, & Shachak, 2011). Progress in psychology has been relatively slow, with health psychology rather than clinical psychology serving as the pioneer (Murray & Chamberlain, 1998).

One of the major restraints to the greater acknowledgment of qualitative research in clinical psychology has been its origins in the scientist practitioner model. This model, developed at the Boulder Conference in 1949 (Petersen, 2007), requires clinicians to both rely on empirical evidence in clinical decision-making and conduct research in their practice (Jones & Mehr, 2007). This conference had widespread implications, ensuring that the majority of clinical training programs include a strong quantitative research dimension, both in the United States and overseas. Despite this impact, however, there is a growing acknowledgement that the aims of the scientist-practitioner model have not been realised (Stricker & Trierweiler, 1995, Chwalisz, 2003). Of particular concern has been a reliance on the randomised control trial, a method that relies on a degree of homogeneity of participants and control of interventions that do not always mirror the complexity of real world clinical practice (Rothwell, 2005). In recent years there have been important calls for greater methodological diversity, most notably by The American Psychological Society (2006) and a widened definition of evidence. The APA recognised that methods need to be chosen based on the questions being asked, rather than predetermined epistemologies and inquiry needs to go beyond outcome to an exploration of process in the therapeutic endeavour (Rhodes, 2012). New areas of inquiry recommended include how clinicians make decisions in a sensitive and flexible manner, the role of race and culture in the process of treatment and the management of the therapeutic relationship. Norcross, Beutler, & Levant (2009) mirror this recommendation, calling for the greater recognition of a host of methodologies, including those available through the traditions of qualitative research. Britain is also now emerging as a major force in qualitative research in psychology, establishing a dedicated section in the British Psychological Society in 2005, now the biggest in the organisation (Frost & Barry, 2010)

Qualitative research in Australian psychology, however, is clearly lagging, with no position statements or advocacy the Australian Psychological Society or the Australian Clinical Psychology Association. Indeed, clinical psychology training in general is conservative, following the traditional scientist-practitioner model, particularly cognitive behaviour therapy, with little recognition of the progressive influence of critical psychology (Holzcamp, 1992), post-modern or discursive therapies (Seikkula & Olsen, 2003, de Shazer, 1994, White & Epston, 1989), or community-based (Henggeler, 2003) and recovery initiatives (George, 2008). This has certainly been the case in the School of Psychology in University of Sydney, with the notable exception of a tradition of interpretative phenomenological analysis in health psychology. Historically, however, the majority of qualitative studies beyond this specialty have been limited to the relatively basic methods of thematic analysis and early grounded theory (Strauss & Corbin, 1990). In the past three years, however, there has been a growing change in this culture, with ten per cent of graduates from the Doctorate of Clinical Psychology completing purely qualitative research theses, and ten per cent of the current cohort conducting the same. A full range of methodologies are now represented, with research exploring topics not typically considered in clinical psychology; hearing voices networks, systemic family therapy, interdisciplinary discourses, interpersonal processes, reflective practice and more. The first four Honours students to conduct qualitative research in the School of Psychology have also graduated during this period with qualitative teaching present in the majority of degrees. I will now endeavour to describe three factors that have contributed to these changes; the development of an off-curriculum co-learning support group for student researchers, an effort to maintain and extend hospitable relations with positivist colleagues and a willingness to be influenced by their insistence on sophisticated and rigorous investigation.

## **Innovation Through Co-Learning**

In 2010 the Qualitative Research in Psychology Group (QRIP) was established in the School of Psychology. The group was developed as a voluntary activity to provide both technical and social support to a small number of students who were marginalised in their use of these methods. A number of principles were established for the group, centred on the concept of co-learning (Wagner, 1997) rather than didactic teaching. Co-learning implies that the academic serves as a 'facilitator of learning' and the student as an 'empowered explorer' (Lin, Oxford & Brantmeier, 2013) and has parallels with the notion of second-order cybernetics from the field of constructivist anthropology (von Foerster, 1974). This concept accepts that the educator is part of the system they endeavour to influence, being influenced in turn, allowing for innovation, rather than teaching from an external position. In QRIP students were encouraged to collectively select subject matter for meetings and to share their experiences with each other. In the first meeting a flexible agenda was set for the next ten fortnightly sessions, including the basics of qualitative research (epistemology, method, reflexivity, interviewing, data collection and analysis, rigour and writing-up) as well as the provision of opportunities for students to bring transcripts to sessions for the purpose of 'collaborative-coding' of interview transcripts (Barbour, 2001).

Over the past two years a wide variety of innovative teaching practices have emerged from this dynamic relationship with students, practices that were co-constructed during sessions, rather than designed by the researcher in advance. A five step process for collaborative coding has been developed to facilitate the development of higher order themes. The group of participants are broken into groups, each reading the same transcript and then interpreting them for tentative codes and meaning. The teams then share their analysis with each other while the researcher listens. The researcher is then interviewed to ascertain what has interested them the most and how they have compared and integrated each team's perspectives. The entire group is then asked to relate any of the insights to their own projects. Regular 'Shut-Up and Write' days are also conducted (Mewburn, Orborne, & Caldwell, 2013), with students and academics spending seven hours together writing in silence with ten minute consultation intervals. An open blog has been developed (<http://qual-rip.blogspot.com.au/>), focussing on technical and experiential posts, now attracting 100 hits a day from 133 countries. We also plan to hold an 'Unconference' (Craig, 2006), an informal participant-driven conference where the agenda is set collectively on the first morning, focussing on solving real research problems, rather than traditional presentations.

Since 2010 QRIP membership has grown from ten to ninety, with interactions occurring at meetings, but also via listserve and the blog. Membership has gone beyond the initial cohort of University of Sydney psychology students and staff and now includes music, engineering, medicine and nursing students from a variety of institutions, allowing for exposure to different methodologies and theoretical lenses (Frodeman, Klein, & Mitcham, 2010).

## **Engaging with Positivist Colleagues: An Ethic of Hospitality**

Epistemological differences between quantitative and qualitative researchers can lead to significant misunderstanding, one characterised as a 'paradigm war' in educational and social research the 1980's (Onwuegbuzie & Leech, 2005). There is some agreement in the literature, however, that this 'war' has largely been settled by the recognition that methods can be mixed on pragmatic grounds, while maintaining the integrity and recognising the incompatibility of differing philosophical traditions (Howe, 1988). In my own setting I have

been particularly influenced by Larner's (2003) reading of Derrida's concept of hospitality. Larner argues that we need to enter into dialogue with the 'other', from a position of generosity, founded on the fact that we feel fully at home in our own paradigm. From this perspective relationships can be enhanced, not by concession but rather by differentiation (Schnarch, 1997). In practical terms this has meant first maintaining a curiosity and respect for empirical methods and their contribution to clinical practice, despite biases and reservations, while confidently advocating for a wide range of qualitative methodologies during seminars, colloquia, learning conferences and informal communication. What has emerged is a rich research portfolio in the Unit, one based on the questions being asked rather than driven by the limitations of specific methods. Mixed methods collaborations have also been conducted, a development predicted as the new paradigm or 'third way' for research (Onwuegbuzie & Leech, 2006).

## **Standards for Research Design**

One of the main concerns expressed by positivist colleagues about qualitative research has been the quality and sophistication of research design, rather than its relativist or social constructionist assumptions. This criticism has validity, especially given the fact that many novice researchers resort to interviews and thematic analysis as a default position for their projects. Much has been written about the difficulty of setting universal standards for qualitative research (Burns, 1989, Howe and Eisenhart, 1990). There is significant tension between those advocating for explicit criteria to support evidence-based practice and those who reject criteria due to methodological diversity (Hammersley, 2007). At the risk of presenting yet another list, however, I have settled on the following standards when supporting my own students. Some focus on rigour and sophistication, but others have an important ethical dimension commensurate with the participatory and discursive ethos of qualitative research. The first of these is not my own, but applied to all students conducting post-graduate research.

### **1. Conduct a systematic review**

All post-graduate research students are expected to conduct a rigorous systematic review as part of their initial research proposal. The review process can be operationalised for quantitative studies (Centre for Reviews and Dissemination, 2009) but is more challenging for qualitative reviews. Data collection and interpretation methods are more diverse and results may be presented in a variety of ways, including themes, models, narrative typologies and theoretical theses. Noyes, Papay & Pearson et al. (2008) provide a considered approach to the systematic review of qualitative research for the Cochrane Collaboration, one that allows the reviewer to choose inclusion criteria and data synthesis techniques depending on methodology and engage in a process of integrating data based on a similar analytic process to grounded theory.

### **2. Conduct your research with participants, not on them**

One of the primary differences between qualitative and quantitative research concerns the power relations between researcher and subject (Cornwall & Jewkes, 1996). Qualitative inquiry is considered to be a researcher-participant co-production (Gergen & Gergen, 2000), with varying degrees of participant involvement in analysis depending on method. In grounded theory, for example, this involvement might be limited to member-checking once data analysis has been completed, with a limited number of new participants interviewed to verify the final model. In narrative inquiry, however, the researcher serves as a ghost or

shadow-writer (Rhodes, 2000), joining and enabling the process of storytelling, but privileging the meaning-making capacity of the other.

### **3. Collect data from more than one source**

There are many sources of data available to the qualitative researcher, from in-depth interviews or focus groups, field notes, kinship diagrams, recordings of interpersonal interactions, non-verbal data templates, diaries and more (Onwuegbuzie, Leech & Collins, 2011). Qualitative research does not adhere to the concept of validity because the aim is not to discover objective truths. Many alternative concepts have been put forward, however, including credibility (Hoepf, 1997) trustworthiness (Davies & Dodd, 2002) and defensibility (Johnson, 1997). This form of rigour is seen as best achieved through triangulation (Golafshani, 2003), a concept that applies to mixed method studies, but also to qualitative studies with multiple data sources (Patton, 2001). Triangulation (Denzin, 1978) is a military navigation metaphor where multiple reference points can be used to identify the exact position of an object (Jick, 1979).

### **4. Reflect on your own beliefs and biases**

Reflexivity is critical for qualitative research (Watt, 2007), given that the researcher is the primary tool for data collection and analysis. In particular the researcher must learn to become more aware of personal and academic values and biases, not necessarily to bracket them out, but to manage their covert influence. This can be supported in many ways, by memoing or journaling throughout the project (Maxwell, 1996) and by drawing situational maps to explore networks of discursive influences, positions and actors involved in the research (Clarke, 2005). Any theoretical positions must be explicitly chosen and stated. Indeed, contemporary qualitative research fully accepts a critical role for theory in interpretation (Kushler & Morrow, 2003).

### **5. Pursue alternative avenues for dissemination**

The traditional vehicle for dissemination of research findings are scholarly peer-reviewed journals. While this remains valid for qualitative research many argue that we also have a responsibility to share findings with other stakeholders who might not have access to or an interest in academic publications (Keen & Todres, 2007). In clinical psychology this is particularly true, given that findings might of direct relevance to those currently struggling with personal or interpersonal difficulties. In our own setting this initiative is still developing amongst qualitative researchers, but we have presented findings directly to clinicians at their professional team meetings, online via the QRIP blog and are currently working on a book of narratives for sufferers of chronic anorexia nervosa, edited by a person who has recovered. On three occasions participants have also been invited to share their liberative stories during professional training courses I have run, thus privileging insider knowledge (Dickerson, 2011) alongside more traditional forms of expertise.

## **Three Examples**

Three examples of research conducted by QRIP members are now presented. These have been selected to demonstrate the direct relevance of qualitative research to clinical practice, the potential sophistication of qualitative methods and the participatory ethics involved. The first is a mixed method study of chronic anorexia nervosa, involving a narrative analysis, the Delphi technique and a randomised control trial. The aim is to test and develop a resource to enhance the motivation of sufferers to engage in treatment, using stories gathered from those who have overcome the illness. The second is a study of adolescent suicidality and acute

mental health units and involves discourse analysis, ethnography, experience sampling and narrative inquiry. The aim is to understand the culture of these units and the effects of admission on the emerging identity of young people over time. The third is a participatory action study that tracks the experience of a team of clinicians over one year as they explore their own childhood family experiences in supervision. The team are involved in all aspects of the research, including design, data analysis and dissemination.

### **Dawson, Touyz & Rhodes. 'Doing the Impossible': The Process of Recovery from Chronic Anorexia Nervosa**

Anorexia nervosa (AN) is a severe and chronic mental illness associated with a vast array of physical complications as well as substantial harmful effects on psychological and social functioning. AN has the highest mortality rate of any mental illness and death is 12 times higher than the annual death rate due to all other causes of death for females aged 15-24 years of age. Those with chronic AN tend to have the poorest outcomes and chronic AN poses a heavy burden on health and social services placing a significant load on parents, carers, and the community. AN is further complicated by the fact that research into the treatment and prevention of the illness has yielded inconclusive results. A major barrier in the field is that there is currently no definitively effective treatment for adults. Patients often associate treatment and recovery with a sense of hopelessness and drop-out from treatment is high. Patients with AN have been found to perceive the illness as having low controllability, low curability and ambivalence about recovery is consistently identified as one of the major challenges to treatment. Treatment that targets low motivation, a fundamental barrier to change is therefore urgently needed. The aim of this series of studies is to develop a trial a pilot intervention for those currently suffering with chronic AN, targeting motivation in particular.

In the first study we aimed to explore the process of recovery over time from the perspective of those who had fully recovered from chronic anorexia nervosa (AN), using stringent recovery criteria. Eight women, assessed as fully recovered from chronic AN, told their story of the process of recovery. Data were analysed using the qualitative method, narrative inquiry. Recovery was identified as a long and complex process that spanned four phases: from being unable or unready to change (Phase One), to experiencing a tipping point where motivation increased and changed in quality (Phase Two), allowing the women to take action against the AN (Phase Three), and finally allowing them to reflect, grow, and rehabilitate (Phase Four). Results provide a framework for understanding this complex process. Findings suggest that full recovery from chronic AN is possible and emphasize the importance of hope, motivation, and self-efficacy in the recovery process.

The second study, currently underway, aims to explore the process of recovery from AN from the perspective of national and international experts in the field. The Delphi method is being used to address the research questions. This method is appropriate when experts are required to exchange opinions to reach consensus when an accepted body of knowledge is lacking (Adler & Ziglio, 1996). The Delphi method is a multi-stage process, typically involving three to four rounds of questionnaires administered online until consensus amongst the panel is reached. In accordance with best research practice for using this method a pre-determined consensus level has been set at 75 percent. That is, when 75 percent of participants are in general agreement the study will conclude.

This will be followed up by a third study, a randomised control trial assessing the efficacy of an online clinical resource for patients with anorexia nervosa developed from the results of the first study. The primary outcome variable will be increases in motivation as measured by

(i) intentions to recover from AN and (ii) stage of change. Patients with all forms of clinically significant AN-type eating disorders will be recruited. This is to test whether the resource is effective across all clinically significant forms of AN and not merely the strict diagnostic criteria for AN, which many patients fall outside of. To ensure significant power and to account for attrition rates at least 100 participants will be recruited for the study. Participants will be recruited through a media release outlining details of the study in print and news media as well as posting details of the study on leading eating disorder websites, blogs, and relevant organisations.

### **Rhodes, Graham, Iedema, Kelly Mikes-Liu & MacDonald. Adolescent Suicidality and Acute Care: Balancing Safety and Growth**

Suicide is the leading cause of death among adolescents in Australia, representing 25% of deaths among those aged 12-24. Research demonstrates that suicidality in adolescents is complex with multiple causes. No clear treatment has emerged but research consistently points to the need for an individualised and multi-element approach, including intervention in family and wider system settings. Many young people will be admitted to acute mental health units for their own safety and be diagnosed with mental disorders and prescribed psychiatric medication. These units have shown to lead to symptomatic improvements but not long term recovery. Many adolescents will also feel disconnected from the real world during their admissions, concerned about their own safety and engage more with direct staff and peers than formal attempts at therapy. The aim of this study is to explore the professional culture and morays of acute child and adolescent inpatient mental health units, the experiences of adolescent patients and the effect of admission on their personal narratives over time. This series will serve as a precursor to a participatory action study, aimed at developing novel interventions or cultural change initiatives in these settings.

In the first study we aim to explore how the different professionals working in these acute units understand the young person's presentation and experience. In particular we aim to investigate if how differing discourses might be either dominant or marginalised, with particular attention to how the medical and therapeutic models might be negotiated between professions. Twenty mental health professionals, including clinical psychologists, nurses, social workers and psychiatrists will be interviewed from four acute units. Discourse Analysis (DA) will serve as the primary analytic tool, one with the way in which language is used to construct social reality.

In the second study we aim to conduct a focussed ethnography, following eight young people experiencing suicidality through an admission. The aim of ethnography is to describe a culture. Focussed ethnography allows for purposive visits, based on observation, rather than actual full-time participation in the setting being studied. Field visits will be made to document three types of events using audio tape, clinical meetings between staff, clinical meetings with young people and/or their families and informal interactions between nursing staff and young people. Audio transcripts will be augmented with written file notes, assessment reports, meeting minutes and 'on-the-spot' interviews.

The third study is a real-time narrative inquiry of young people experiencing suicidality admitted to acute mental health units. Forty young people will be asked to record answers to specific questions concerning their understanding of themselves using the Experience Sampling Method (ESM), a method that maximizes the validity of data collected by avoiding or minimizing retrospective recall. Participants are given hand-held devices (mobile phones) which will beep three times a day during the admission and once per week for two months

afterwards. These signals serve as prompts for participants to respond to specific questions relating to their developing identity. Responses will be written into narrative form and presented to the young person for clarification and editing before between-participant coding.

### **Renshall, Brown & Donnelly (2013) Family of Origin Coaching as Supervision for Child and Adolescent Mental Health Clinicians: A Participatory Action Study.**

The role of the therapist as a person rather than only as a technician has become increasingly important in family therapy since the post-modern turn. Despite this there is a paucity of research exploring supervision models that focus on self-reflection and personal development, as opposed to clinical competence. Some have argued that reflective practice can be promoted incidentally, through focussing on theory and technique, without the need to explicitly discuss the personal material of the therapist. Proponents of Bowen's model, however, take a more direct approach, arguing for Family of Origin (FoO) coaching. This model involves active reflection on the therapist's own family of origin experiences, with the aim of enabling a de-triangulation from emotional alliances in the therapy room.

This study aimed to track the experience of a group of six clinicians, both clinical psychologists and social workers, working in a child adolescent mental health service, as they participated in FoO coaching for one year. The researchers and participants jointly devised the following research aims. 1. What effect does FoO coaching have on our clinical work? 2. How can FoO coaching be modified or improved based on our experience? A Participatory Action Research framework was chosen. This was seen as particularly important given the potentially confronting nature of FoO coaching. This approach involves cycles of planning, observing and acting and in this case allowed changes to be made to the supervision program throughout its implementation if necessary. Changes could be made immediately, thus minimising any harm experienced during the development stage of an intervention. The choice of PAR was also informed by the commitment of both the researchers and participants to democratic, transparent and non-pathologising relationships, a joint set of values that were informed by the fact that all had been trained in, or exposed to, the principles of contemporary family therapy. A variety of benefits were reported, including personal development, an enhanced empathy towards clients and an ability to better understand stressful team dynamics. Issues of confidentiality and safety needed to be addressed carefully throughout the project, with both content and process modified due a wider context of organisational change and stress.

### **Conclusion**

The aim of this paper has been to demonstrate how qualitative methods have been introduced into a clinical psychology program. These methods were initially marginalised in a field dominated by the scientist-practitioner model, but are now accepted by quantitative colleagues and becoming part of the curriculum. A variety of strategies have been used to bring this about, some emerging from interactions with students and other from interactions with colleagues. A critical contribution has been to develop a groundswell of support for qualitative methods amongst students, providing an off-curriculum forum for the development of technical knowledge and sharing of expertise. This forum has been characterised by collaboration and innovative teaching practices, including a significant on-line presence. The second has been to advocate for qualitative methods with colleagues, educating them about the potential contributions, while maintaining a respect for their own values and expertise. The process of influence has been mutual. While they have accepted



qualitative methods and are collaborating in mixed studies I have been challenged to match their commitment to sophistication and rigour.

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